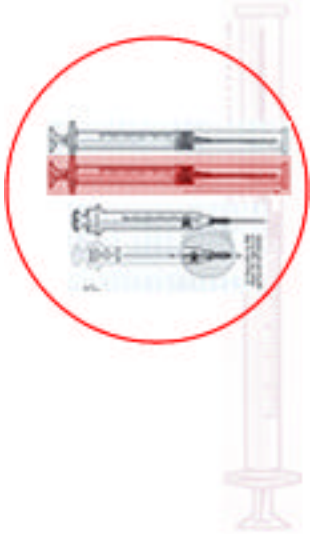
NIOSH recommends that health care facilities use safer medical devices to protect workers from needlestick and other sharps injuries. Since the passage of the Needlestick Safety and Prevention Act in 2000 and the subsequent revision of the OSHA Bloodborne Pathogen Standard, all health care facilities are required to use safer medical devices.

SAFER MEDICAL DEVICE IMPLEMENTATION IN HEALTH CARE FACILITIES

SHARING LESSONS LEARNED

NIOSH has asked a small number of health care facilities to share their experiences on how they implemented safer medical devices in their settings. These facilities have agreed to describe how each step was accomplished, and also to discuss the barriers they encountered and how they were resolved, and most importantly, lessons learned.



Phase 5 Report
Evaluating Safer Medical Devices

This nursing care center is a 500-bed JCAHO accredited long-term care facility that provides 24-hour care to psycho-behavioral and medically/physically handicapped residents with intermediate and skilled nursing care needs. Provision of care is accomplished by 600 employees in the following departments: Medical, Nursing (including Infection Control), Quality Improvement, Respiratory Therapy, Activity Therapy, Occupational Therapy, Pharmacy, Chaplaincy, Physical Therapy, Nutritional, Environmental, Education, Speech & Hearing, Social Work, Health Information, Supply, Volunteer, Physical Plant and Employee Health.

SUMMARY

Per contractual design, the phase five report requirement involved implementation and monitoring of the device trialed by users. As evidenced by our team's decision to retain the current sharps disposal container, there will be no implementation of a new device. Instead, the team recommended: evaluation of the need for brackets to secure the container to the medication cart; compliance evaluation of safety device activation; re-education relating to activation compliance and over-filling compliance.

Sharps disposal containers are located in a recessed well of the medication cart. During our last DHEC survey for certification, surveyors expressed concern for resident safety and possible tampering because of this placement. We were able to provide documentation of OSHA regulations, NIOSH recommendations and evidence of the sharps injury prevention team. The DHEC surveyors accepted our justification of their concern without resulting citation.

When the team evaluated the location of the sharps disposal container, catalogs were obtained from the medication cart manufacturer and team members discussed using a locked bracket attachment. The team decided not to use the bracket attachment due to interference with the disposal process and lowering the sharps container on the cart would increase accessibility to wheelchair residents.

Our team also decided to monitor the compliance of safety device activation. Three team members examined the sharps disposal containers throughout the facility and documented compliance with product assembly, over-filling, and safety-device activation. Observations included two sharps disposal containers that were assembled incorrectly and three containers were over-filled. Improvement was noted from a previous monitor in disposing the butterfly venipuncture device with a vacutainer holder attached. However, there were several occurrences of disposal of butterfly venipuncture devices without safety device implementation.

Based on the outcome of the above monitor, the team concluded that education on safety device activation was essential. It has been planned for an independent firm to

conduct education regarding sharps safety and discover the best educational strategy that impacts behavioral compliance for sharps safety.

LESSONS LEARNED

The team initially felt that the sharps container was problematic but discovered that procedural compliance was more important in preventing sharps injury. When the team decided not to implement a new container, rather than disbanding, they expressed the desire to improve the sharps safety process. After the educational research firm has concluded and presented their findings, the team can prioritize and choose the best methods that impact the facility's sharps safety program.

The team will also continue to annually evaluate all sharps used in the facility and has identified injectables as the next sharp to be evaluated.

STAFF HOURS AND OTHER COST ISSUES

Cost issues are broken down into two areas: materials and staff hours. Materials used for this step included computer, paper, and long-distance phone calls. Staff hours for conducting the monitor and meetings are reflected in the following chart:

Type of Staff	Hours Spent on Phase V
Team Coordinators	8
Management	1
Product Users	5
Total	14